

Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally & Linguistically Centered Integrated Health Care Approach

Consensus Statements and Recommendations

June 2012

U.S. Department of Health and Human Services
Office of Minority Health and
Hogg Foundation for Mental Health



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ADVANCING RECOVERY AND WELLNESS IN TEXAS

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This publication is based on research conducted by the Hogg Foundation for Mental Health and proceedings from the 2011 national consensus meeting titled: Eliminating Behavioral Health Disparities through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minority Populations and Those with Limited English Proficiency.

The views, opinions and content expressed in this publication are those of the authors and conference participants and do not necessarily reflect the views, opinions or policies of the Office of Minority Health, the U.S. Department of Health and Human Services, or the Hogg Foundation for Mental Health.

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Acknowledgements

We would like to thank everyone who assisted in the research, planning and execution of the expert consensus meeting, as well as with the writing and editing of this document.

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Introduction and Background

INTEGRATION:

The Future of Health Care in America

Research shows that treating behavioral health conditions as early as possible, holistically, close to a person's home and community, and in a culturally and linguistically appropriate manner leads to the best health outcomes. Integrated behavioral and physical health care is gaining significant momentum across the nation as a preferred approach to providing optimal care for behavioral health conditions. This approach is more accessible and less stigmatizing than referral to specialty behavioral health care settings.

The World Health Organization (2011) has recommended integrating mental health services into primary care as the most viable way of closing the gap in prevention and treatment of mental illness. Primary care settings are often the first point of contact for all health issues and therefore, the gateway to identifying undiagnosed or untreated behavioral health conditions. A successful approach would require primary care settings to incorporate early screening, identification and treatments for behavioral health disorders, while ensuring the presence of a culturally diverse workforce that treats the whole health patient/consumer.

Providing health care to the community at the "point of entry" in the system is the key to wellness. In particular, racial and ethnic minority populations and individuals with limited English proficiency (LEP) are more likely to seek and receive behavioral health care in primary care settings. Many reasons have been cited for this trend, including lack of access to mental health specialists, income and insurance issues, stigma surrounding mental illness, the level of trust in the relationship with the family physician, language and cultural barriers that hinder communication and delivery of services (President's New Freedom Commission on Mental Health, 2003). Integrated health care approaches must respect the whole person, work across the life span, include prevention and early intervention methods,

and be person centered, strength based and recovery focused. Providers that respect the cultures, languages and world views of the people they serve are more successful in engaging and activating individuals, families and communities to be an active participant in their own health care.

HEALTH EQUITY:

The Role of Integration in Eliminating Health Disparities

In a strategic effort to improve the health status of populations most impacted by disparities, in 2010, the U.S. Department of Health and Human Services' Office of Minority Health (OMH) entered into a collaborative agreement with the Hogg Foundation for Mental Health in Austin, Texas to investigate the role and impact of integrated care in promoting health equity and eliminating behavioral health disparities. The scope of the collaboration was to identify and recommend culturally and linguistically competent elements, strategies and practice innovations to be incorporated into current models and approaches of integrated health care. Additional goals were to identify effective strategies for implementing those changes and to create a new knowledge base for this paradigm. Key activities and work products were defined and aligned strategically to provide the greatest impact when promoting and implementing integrated health care in culturally and linguistically diverse communities, including persons with LEP. A literature review was conducted to examine the evidence base and literature of integrated health care regarding racial and ethnic minorities and populations with LEP. This literature review was then disseminated to a select group of leading national experts for review and consideration, setting the stage for a robust dialogue to take place at a national consensus meeting.

OMH and the Hogg Foundation convened a two-day expert panel meeting in Austin, Texas on November

7-8, 2011, "Eliminating Behavioral Health Disparities through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minority Populations and Those with Limited English Proficiency."

Recognized experts in the fields of health, mental health and addictions, integrated care, and cultural and linguistic competency met to share best practices, offer insights and provide recommendations to help create national models to improve integrated health care for racial and ethnic minority and LEP populations.

This report contains the consensus statements and recommendations from the experts meeting and is the fourth in a series of OMH-sponsored projects to address specific areas of need for underserved, targeted communities. The other three reports are available online at <http://minorityhealth.hhs.gov/> or <http://www.hogg.utexas.edu/>.

- *Movilizandonos por Nuestro Futuro: Strategic Development of a Mental Health Workforce for Latinos* (2010)
- *Pathways to Integrated Health Care: Strategies for African American Communities and Organizations* (2011)
- *Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action* (2012)

LITERATURE REVIEW: An Analysis of Evidence-Based Studies and Reports

Katherine Sanchez, LCSW, PhD, the project's science writer, prepared a technical report, "Eliminating Disparities through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minority Populations and Persons with Limited English Proficiency: A Review of the Literature."

The technical report provides a comprehensive summary of literature on the state of integrated care for racial and ethnic minority and LEP populations, highlighting cultural and linguistic competency and best practices in integrated health care. The report also examines highly relevant materials including reports and articles from both peer and non-peer reviewed publications; compiles the available evidence from practice; and summarizes the knowledge base of cultural and linguistic competence in the delivery of primary health and behavioral health care.

A key purpose of the report was to provide a context for the expert panel meeting, setting a platform of identifying best practices in integrated health care while examining approaches on key elements needed to improve overall health outcomes and reduce health and behavioral health disparities. Experts invited to the meeting received the draft report in advance.

The Consensus Process and Outcomes

FOCUS ON THE ISSUES:

Outcomes of the National Experts Meeting

The goal of the national experts meeting was to convene a panel of national experts to advance the understanding of optimal integrated care and best practices for traditionally underserved communities. The meeting opened with welcoming remarks from Teresa Chapa, PhD, MPA, senior policy advisor for Mental Health at OMH, and Octavio N. Martinez, Jr., MD, MPH, MBA, executive director of the Hogg Foundation for Mental Health.

Dr. Chapa provided background on the collaboration with the Hogg Foundation and prior activities and reports sponsored by OMH to enhance behavioral health equity among racial and ethnic minorities, including the integration of behavioral health and primary care. She described the objectives of the meeting as follows:

1. Identify promising and practice-based approaches for delivering integrated health care to racial and ethnic minorities and populations with LEP.
2. Define and recommend key components of ideal models and approaches to delivering integrated health care to racial and ethnic minorities and populations with LEP.
3. Discuss implementation, assessment and future research considerations related to delivering integrated health care to racial and ethnic minorities and populations with LEP.

Dr. Sanchez provided an overview of the technical report and responded to questions and comments.

Meeting participants provided extensive feedback and offered suggestions for enhancing content and other considerations relevant to care for racial and ethnic minority and LEP populations. A final version of this technical report will become available in summer 2012.

Topics for discussion were identified from the technical report and participants were asked to offer practice recommendations from the field that have demonstrated success and hold promise for improving access, treatment and health outcomes for racial and ethnic minorities. Issues discussed included: language accessibility and linguistic competency in the screening; diagnosis and treatment of mental health and substance use disorders and comorbidities; preference for treatment in primary care for racial and ethnic minorities; methods to strengthen the quality of primary care, access to care and continuity of care for LEP populations.

The experts developed consensus statements to inform the governance and operations of clinical and community practice, research, evaluation and policy. The governance structure and organizational culture of a system or organization set the tone for clinical and community practices that are sensitive and responsive to the needs of racial and ethnic minorities. Practice-based research and continuous comprehensive evaluation are critical to examining organizational efforts and implementing effective policy.

The experts also made recommendations that are centered on key integrated health care strategies relevant to racial and ethnic minority populations and are outlined in five essential areas of care: 1) patient, 2) practice, 3) community, 4) system and 5) workforce.

The consensus statements and recommendations are intended to inform a broad audience of health and behavioral health care providers, educators, advocates, patients/consumers and their families, researchers and policy makers. The goal of integrated care for racial and ethnic minority and LEP populations is to eliminate

health disparities by improving health and behavioral health status. Suggested strategies will require broad support from the public health, behavioral health and medical sectors in general. Strategies to improve the health status of our diverse communities must also include workforce diversification and approaches designed to enhance engagement and adherence to treatments.

Consensus Statements

A framework (see Appendix A) for improving access to care for traditionally underserved racial and ethnic minority communities requires expanding services beyond the traditional domains of health and behavioral health care delivery systems. Treatment planning must be person-and family-centered in order to increase engagement in the elements of integrated care.

Efforts to eliminate health disparities must incorporate strategies for addressing social determinants of health, such as location of the integrated health care center, availability of transportation, hours of operation, and levels of acculturation, socioeconomic status, community centeredness and health literacy. The development of a multidisciplinary, culturally and linguistically competent workforce is essential.

Specifically, the group of experts collectively agreed to the following five statements that define a culturally and linguistically competent approach to integrated health care.

1. Integrated care organizations and teams will be culturally and linguistically competent and responsive to the needs of the communities they serve, including being located in reasonably accessible areas and providing flexible hours of service.
2. Integrated care teams will actively engage with patients/consumers, their family members, and their community across the lifespan. The team must be multidisciplinary and cross-trained in health and behavioral health, thereby leveraging the strengths of the team.
3. Integrated care teams will recognize and incorporate the strengths of patients/consumers, their family members and their cultures, permeating all levels of assessment, diagnosis and intervention.
4. Integrated care organizations will ensure one health and behavioral health history and treatment plan for each patient/consumer, under one roof, with a wellness component and a focus on health promotion, prevention and person-centeredness across the life-span.
5. Integrated care organizations will participate as a member of a learning community in which health and behavioral health professionals gain knowledge, develop data collection plans, and foster the growth of an ethical workforce that represents the diversity of the community with language and cultural competency.

Recommendations

Seamless integrated health and behavioral health care offered in a culturally and linguistically competent, person-centered framework that adequately reduces barriers will require implementation of certain best practices in integrated health care at the individual, community, practice, system and workforce level.

The following recommendations represent key strategies and examples from practice for better dissemination and implementation of integrated health care to meet the needs of racial and ethnic minority populations.

PATIENTS/CONSUMERS

Language accessibility and linguistic sensitivity are essential elements to the treatment of mental and physical health conditions. Accurate screening, diagnosis and treatment are entirely dependent on a linguistically accurate interview that acknowledges cultural values, spirituality and community/family beliefs about behavioral health and medicine.

Additionally, access to information on the Internet has dramatically changed the role of the patient/consumer and has provided new opportunities for true partnership and collaboration between patients/consumers and providers. Health care should have a particular focus on linking problem-solving skills and patient/consumer education to disease self-management and socioeconomic stressors created by an illness.

Key Strategies Identified

- Conduct comprehensive assessments that are culturally and linguistically competent to understand cultural values, beliefs and constructs and how they may inform the symptom picture, diagnosis and treatment.
- Develop patient/consumer-driven treatment plans that activate patients/consumers in their own health care.

EXAMPLE: Charles B. Wang Community Health Center

The Mental Health Bridge Program at the Charles B. Wang Community Health Center in New York City integrates mental health services in a primary care setting. This was designed to address and reduce the stigma attached to mental health services that is deeply rooted within the Chinese community. A bilingual and bicultural mental health team consults with primary care providers through assessment, medication recommendations, and counseling to adults, children and families. With no distinction between treatment rooms for primary and mental health care, providers have open communication in a combined electronic health record and informal communication is encouraged. To increase patient/consumer trust and reduce fears of seeking mental health services in a medical setting, records are strictly confidential. Only those staff directly involved in treating the patient/consumer may gain access to mental health information. The program has successfully reached its original goal of providing mental health treatment to a population that traditionally stigmatizes mental health conditions and has a limited understanding of Western concepts of mental health and mental illness.

<http://www.cbwchc.org>

EXAMPLE: Atlanta Clinic for Education, Treatment and Prevention of Addiction

The Atlanta Clinic for Education, Treatment and Prevention of Addiction (CETPA) in Atlanta, Georgia is a full-service behavioral health agency, providing services in English and Spanish to their diverse Latino community. Their specialty includes cultural and linguistic competency in mental health and substance use assessments and treatments. One practice example is from a monolingual Spanish-speaking Latino client seeking help for his substance abuse and medical problems. He believed his problems were caused by a curse placed on him by an ex-girlfriend. The bilingual and culturally competent clinicians demonstrated a deep understanding and respect of the client's presenting problem and cultural beliefs. In order to engage him fully in treatment, the clinician helped him also understand the problem from a behavioral health perspective. A curandero, or indigenous healer, was added to complement the evidence based treatments. <http://www.cetpa.org/>

EXAMPLE: Mile Square Health Center

The University of Illinois Hospital & Health Sciences System – Mile Square Health Center (MSHC) is a federally qualified health center (FQHC) that provides comprehensive health care services to the predominantly African American residents of the Chicagoland area at multiple locations throughout the city. Integration of behavioral health services into a primary care setting, coupled with staff possessing both expertise in behavioral health and experience working in African American communities, careful matching of provider and patient, and utilization of culturally sensitive engagement processes results in increased patient engagement. Examples of behavioral health/substance use services embedded at MSHC include specialized and intensive care for patients with severe and persistent mental illness, a community-based substance use organization that provides peer counseling services led by African Americans in recovery and/or with a personal history of substance use to enhance patient activation and advance recovery and wellness, and a research project funded by the

Robert Wood Johnson Foundation to provide behavioral health services to ethnic minority youth (adolescents). http://hospital.uillinois.edu/Patients_and_Visitors/Mile_Square_-_Federally_Qualified_Health_Center.html

PRACTICE

At the practice level, patients/consumers should be offered their preferred choice of first-line treatment options, including information, education and psychotherapy in place of or in addition to psychotropic medication. Family members including extended kinships and significant others should be included in treatment if preferred by the patient/consumer. The emphasis in many ethnic cultures is on interdependency, the importance of relying on one another in times of need. Patient/consumer education and homework materials should be culturally, linguistically, idiomatically and literacy-level appropriate to be consistent with language access competency.

Key Strategies Identified

- Develop and share appropriate tools that go beyond just the standard measurement of symptoms.
- Build understanding by cross-training providers and exposing them to other systems.

EXAMPLE: Center for Native American Health

For the Native American community in New Mexico, the Center for Native American Health (CNAH) strives to improve the overall health of Native Americans in New Mexico. CNAH began by establishing strong networks with tribal communities, based on principles of consultation and collaboration in all aspects of public health policy, research and service provision. CNAH has

also been a vigorous advocate of tribal and indigenous values and perspectives, including Native American student development in the health professions. In an attempt to create culturally respectful mental health services, CNAH found that the use of focus groups and vignettes were beneficial to patients/consumers in improving access to services for understanding depression and other mental health concerns. The women in the focus group wanted a community health worker to make home visits and help inform and educate them about depression from a layperson's perspective. Men, however, expressed the desire to meet and talk with other Native American men at a neutral location instead of a primary care or mental health service setting. Hearing the case vignette was critical to opening the door to discussion, leading to improved diagnosis, engagement and treatment. <http://hsc.unm.edu/community/cnah/>

EXAMPLE: New York State Psychiatric Institute

The Center of Excellence for Cultural Competence at the New York State Psychiatric Institute developed the "Depression Fotonovela," a culturally and linguistically appropriate health literacy tool designed to raise awareness, provide education and reduce barriers to depression care in the community. These commonly known soap opera stories are published in the commonly used popular style of a comic book, to inform and educate Latinos about depression and to eliminate powerful negative connotations associated with the treatment of mental health conditions. http://nyspi.org/culturalcompetence/what/project_summary.html

EXAMPLE: Proyecto Nueva Vida

Proyecto Nueva Vida (PNV), with seven locations in Bridgeport, Conn., is a multi-provider collaborative program that addresses cultural and gender-specific needs of Latino men and women with behavioral health conditions, criminal backgrounds, at-risk medical issues and vocational needs. PNV employs culturally and linguistically competent practitioners who are aware of how belief systems play an important role in

the way behavioral health and physical illnesses are perceived, understood and treated. These practitioners also incorporate other Latino-oriented services into the recovery process including, churches, spiritual healers and community leaders. PNV's model builds on the recognition that there is a deep cultural sense of family commitment, obligation and responsibility and thus engages family members (including extended family and those not related by blood or marriage) who are identified by Latino program participants in their treatment and recovery process. <http://www.casaincct.org/proyectonuevavida.html>

COMMUNITIES

Academic-community partnerships, in which community agencies collaborate with research experts, can examine implementation strategies for underserved populations, offer inclusion of diverse perspectives to address stigma, and implement community-based participatory research initiatives. Strategies for outreach and engagement of hard-to-reach populations are essential to convey the importance of screening for mental health issues and inform them of their role in chronic disease management.

Key Strategies Identified

- Create culturally responsive, asset-based environments where the innate strengths of the community are being tapped.
- Use community-based participatory approaches to help communities define the parameters and evidence.
- Identify and empower leaders from within the community.
- Provide health/behavioral health education wherever people are in the community.

EXAMPLE: Project Brotherhood

Project Brotherhood in Chicago provides free health care without appointments and during evening clinic hours to make integrated care more available to African American men. The project hired and trained a barber to provide health education, to serve as an advocate for African American men without access to health care, and to create a male-friendly environment to reduce mistrust of the health care system. They also provide fatherhood classes and produced a comic book, "County Kids," that discourages violence and teaches children how to deal with conflict without resorting to violence.

<http://projectbrotherhood.net>

EXAMPLE: University of California at Irvine

The "Reducing Racial Disparities in Diabetes: Coached Care Project" at the University of California at Irvine is designed to reduce disparities in health care for Latinos and Asian Americans with diabetes. Care is provided in a community setting and teaches ethnically diverse patients to take an active role in designing their treatment regimen in a way that is consistent with their preferences, culture and lifestyle. Community-based ethnic minority coaches who themselves have diabetes are recruited from the target communities, trained and monitored for quality of services. <http://www.medicine.uci.edu/r2d2c2>

EXAMPLE: Bienvenido Program at Northeastern Center

The Bienvenido Program at Northeastern Center in Kendallville, Ind., provides prevention, treatment and inpatient care to people in northeastern Indiana. After a large influx of Latino immigrants in the 1990s, the Northeastern Center found that local Latinos had a high incidence of depression and substance abuse and a very low usage of mental health services. The Bienvenido Program is a prevention and intervention program that addresses the migration experience and acculturative stressors encountered by Latino immigrants. The program trains and empowers local facilitators in a strengths-based mental health promotion curriculum that focuses on building the emotional and behavioral

health of Latinos and helps reduce the risk of reliance on substance abuse due to potentially living in an ongoing marginalized social status. The Bienvenido curriculum has become a dual vehicle to build facilitator knowledge and enhance protective factors in the Latino immigrant.

<http://www.necmh.org>

HEALTH CARE SYSTEMS

Health care system factors that result in barriers to health and behavioral health care for racial and ethnic minorities include: limited provider access; lack of health insurance; poor-quality patient education and understanding of their condition; and large, cumbersome health systems that intimidate and bar easy access. Limited English-language proficiency, limited medical literacy, geographic inaccessibility and lack of medical insurance are all more common among immigrants, minority populations, and people living in rural, frontier and U.S.-Mexico border areas. At the system level, a supplemental patient/consumer navigation intervention can address clinic and system communication barriers, facilitate access to community resources, and locate patients/consumers who miss appointments.

Key Strategies Identified

- Provide services where needed.
- Ensure institutions reflect the populations they serve.
- Address cultural and linguistic diversity, including professional culture.
- Evaluate practice for efficacy.

EXAMPLE: Children's Hospital & Research Center Oakland

The Comprehensive Sickle Cell Center at Children's Hospital & Research Center Oakland in Oakland, Calif., is based on a co-location model that applies holistic

principles to the care and treatment of individuals with sickle cell disease and related conditions. The center operates from an integrative health perspective for both inpatient and outpatient care. In addition, the children's care team interfaces with an adult multidisciplinary team to improve patient/consumer transition and coordinate services throughout the health care system for patients/consumers whose illness impacts several family members across the lifespan. The center also partners with community-based nonprofit organizations and endeavors to ensure that all patients/consumers with sickle cell disease have a medical home and primary care interface with behavioral health, education and vocational components. http://www.chori.org/Centers/Sickle/Sickle_Main.html

EXAMPLE: Connecticut Latino Behavioral Health System

The Connecticut Latino Behavioral Health System initiative integrates a comprehensive qualitative and quantitative evaluation designed to assess the program at three levels: organizational, staff and patient/consumer. Evaluation at the organizational level included the development and preliminary pilot implementation of a new instrument, The Cultural Competency Index. The instrument was designed to evaluate culturally responsive clinical services and is being measured at three time points. Evaluation at the staff level includes pre- and post-training evaluations, satisfaction with trainings, and random tape ratings to assess for language fluency and the integration of Latino cultural values in treatment. Data from the organizational and staff measures currently are being analyzed. <http://www.ctlbhs.org>

EXAMPLE: Dimock Center

The Dimock Center in Boston, founded in 1862, was the first hospital in New England opened and operated by women for women and holds a significant place in the history of women in medicine. Dimock provides programs and services that are all carefully designed, monitored and integrated to meet an individual or family's health and human service needs. It provides

comprehensive health services including substance abuse and mental health. The center has two mental health clinicians, a pediatric social worker, and a child and adolescent psychiatrist. The clinicians operate in 10 schools during the day and in the clinic after hours to maximize availability and access. The Dimock Center practices a "warm hand-off" approach with a multidisciplinary health and behavioral health team. <http://dimockcenter.org>

WORKFORCE

Interdisciplinary mental and behavioral health training programs that focus on models of integrated primary care are examples of partnerships designed to reduce minority health disparities. Examples of these include medical homes, team management of chronic disease and specific models that integrate physical and mental health services. Other workforce development strategies include racial/ethnic minority patient/consumer navigators, community health workers/promotores de salud, and health advocates that reach out to the community to provide education, self-management skills, support and empowerment.

Key Strategies Identified

- Build a diverse multidisciplinary workforce.
- Attract and retain bilingual/bicultural providers.
- Identify and engage individual health care workers early in their studies/career.
- Provide in-culture and in-language supervision.
- Build and support diverse, empowered leadership.

EXAMPLE: Connecticut Latino Behavioral Health System

The Connecticut Latino Behavioral Health System is a collaborative of 13 behavioral health and primary care providers. The system employs unique strategies to successfully recruit and retain bilingual/bicultural professionals and provide ongoing training and consultation on topics related to Latino mental health, addictions and co-occurring conditions. The system created a training academy to enhance the knowledge base, skill set and attitudes of the behavioral health workforce at all levels of the organizational spectrum (administrative, management and clinical). Training topics have included current issues in Latino behavioral health including engagement strategies, clinical interviewing and assessment, Latino cultural values, and the impact of immigration and acculturation.

<http://www.ctlbhs.org/training.html>

EXAMPLE: Cherokee Health Systems

Cherokee Health Systems (CHS) in east Tennessee continuously seeks to expand its capacity and diversity through ongoing recruitment strategies for multilingual staff from all cultural backgrounds. CHS employed a full-time Burundi interpreter to work at the front desk of their largest inner city clinic, which serves the local African refugee population. They also retained a multilingual psychologist who speaks Spanish, French and Portuguese who works via tele-health technology from her home in Miami, Florida.

CHS ensures that job advertisements reflect a desire to hire a diverse multilingual staff by using targeted techniques to recruit particular population groups. To recruit Latino staff, CHS targets specific community locations and publications, as well as works with existing bilingual staff to assist in recruitment efforts. Another effective retention strategy has been to offer advanced training, such as certified nursing assistant or other health-related courses, to bilingual staff. <http://www.cherokeehealth.com>

EXAMPLE: Hogg Foundation for Mental Health

In an effort to increase the number of highly trained, culturally and linguistically diverse and consumer-oriented mental health workers in Texas, the Hogg Foundation for Mental Health launched the Bilingual Scholarship for Mental Health Workforce Diversity initiative. This program offers full-tuition scholarships for Spanish-speaking graduate social work students at twelve Texas universities accredited by the national Council on Social Work Education. Upon graduation, the recipients commit to working in Texas providing mental health services for a period equal to the timeframe of the scholarship. As the largest category of mental health service providers in the country, masters-level trained social workers can help close the workforce and language gap between supply and demand for mental health services. A total of 109 scholarships have been awarded to students at twelve Texas graduate schools through the spring 2012 semester. <http://www.hogg.utexas.edu>

Conclusion

Based on the most current and relevant literature, a panel of national experts has clearly concluded that the improvement of behavioral health and physical health outcomes and the elimination of disparities for racial and ethnic minority and LEP populations can best be addressed by the integration of behavioral health and primary care services. The panel's consensus statements and recommendations presented in this document are intended to improve health status for traditionally underserved populations. They describe key strategies already in place and successfully being used by integrated health and behavioral health care practices.

Future efforts must focus on the specific behavioral health care needs of populations who prefer treatment

from their primary care physician and for whom disparities in behavioral health care prohibit access and result in poorer quality of care. Of absolute importance is a linguistic and culturally competent, patient/consumer-centered framework that adequately addresses barriers.

The suggested strategies outlined in this report will require the comprehensive, persistent commitment of local, state and national leaders, especially as they relate to funding mechanisms, barriers that impede implementation, policies that help grow and sustain integrated health care programs, and data collection and research that enhance our knowledge base of how best to improve America's health care system.

References

- Alliance for Health Reform. (2006). Racial and Ethnic Disparities in Health Care. from http://www.allhealth.org/publications/pub_38.pdf
- Bao, Y. H., Alexopoulos, G. S., Casalino, L. P., Ten Have, T. R., Donohue, J. M., Post, E. P., Schackman, B. R., & Bruce, M. L. (2011). Collaborative Depression Care Management and Disparities in Depression Treatment and Outcomes. *Archives of General Psychiatry*, 68(6), 627-636.
- Bauer, A. M., Chen, C.-N., & Alegría, M. (2010). English language proficiency and mental health service use among Latino and Asian Americans with mental disorders. *Medical Care*, 48(12), 1097-1104.
- Bazargan, M., Bazargan-Hejazi, S., & Baker, R. S. (2005). Treatment of self-reported depression among Hispanics and African Americans. *Journal of Health Care for the Poor and Underserved*, 16(2), 328-344.
- Betancourt, J. R. (2006). Improving Quality and Achieving Equity: *The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*: The Commonwealth Fund.
- Bower, P., & Gilbody, S. (2005). Managing common mental health disorders in primary care: conceptual models and evidence base. *British Medical Journal*, 330(7495), 839-842.
- Brach, C., & Chevarley, F. M. (2008). *Demographics and Health Care Access and Utilization of Limited-English-Proficient and English-Proficient Hispanics*. Rockville, MD: Agency for Healthcare Research and Quality.
- Bravemen, P., & Egerter, S. (2008). *Overcoming Obstacles to Health*. Princeton, N.J.: Robert Wood Johnson Foundation.
- Butler, M., Kane, R., McAlpine, D., Kathol, R., Fu, S., Hagedorn, H., & Wilt, T. (2008). *Integration of Mental Health/ Substance Abuse and Primary Care*. Rockville, MD: Agency for Healthcare Research and Quality.
- Cabassa, L. J., Molina, G. B., & Baron, M. (2010). Depression Fotonovlea: Development of a Depression Literacy Tool for Latinos With Limited English Proficiency. *Health Promotion Practice*, Epub ahead of print.
- Centers for Disease Control and Prevention. (2010). Current depression among adults - United States, 2006 and 2008. *MMWR*, 59(38), 1229-1235.
- Centers for Disease Control and Prevention. (2011). *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011–2015*. Atlanta: U.S. Department of Health and Human Services.
- Centers for Disease Control and Prevention. (updated 2011). Racial and Ethnic Approaches to Community Health (REACH). from <http://www.cdc.gov/reach/>
- Changing Minds Advancing Mental Health for Hispanics. (2002). *Comprehensive In-Depth Literature Review and Analysis of Hispanic Mental Health Issues with Specific Focus on Members of the Following Ethnic Groups: Cubans, Dominicans, Mexicans and Puerto Ricans*. Mercerville, N.J.: New Jersey Mental Health Institute, Inc.
- Chapa, T., & Acosta, H. (2010). *Movilizandonos por nuestro futuro: Strategic development of a mental health workforce for Latinos: Consensus statements and recommendations*. Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health and the National Resource Center for Hispanic Mental Health.

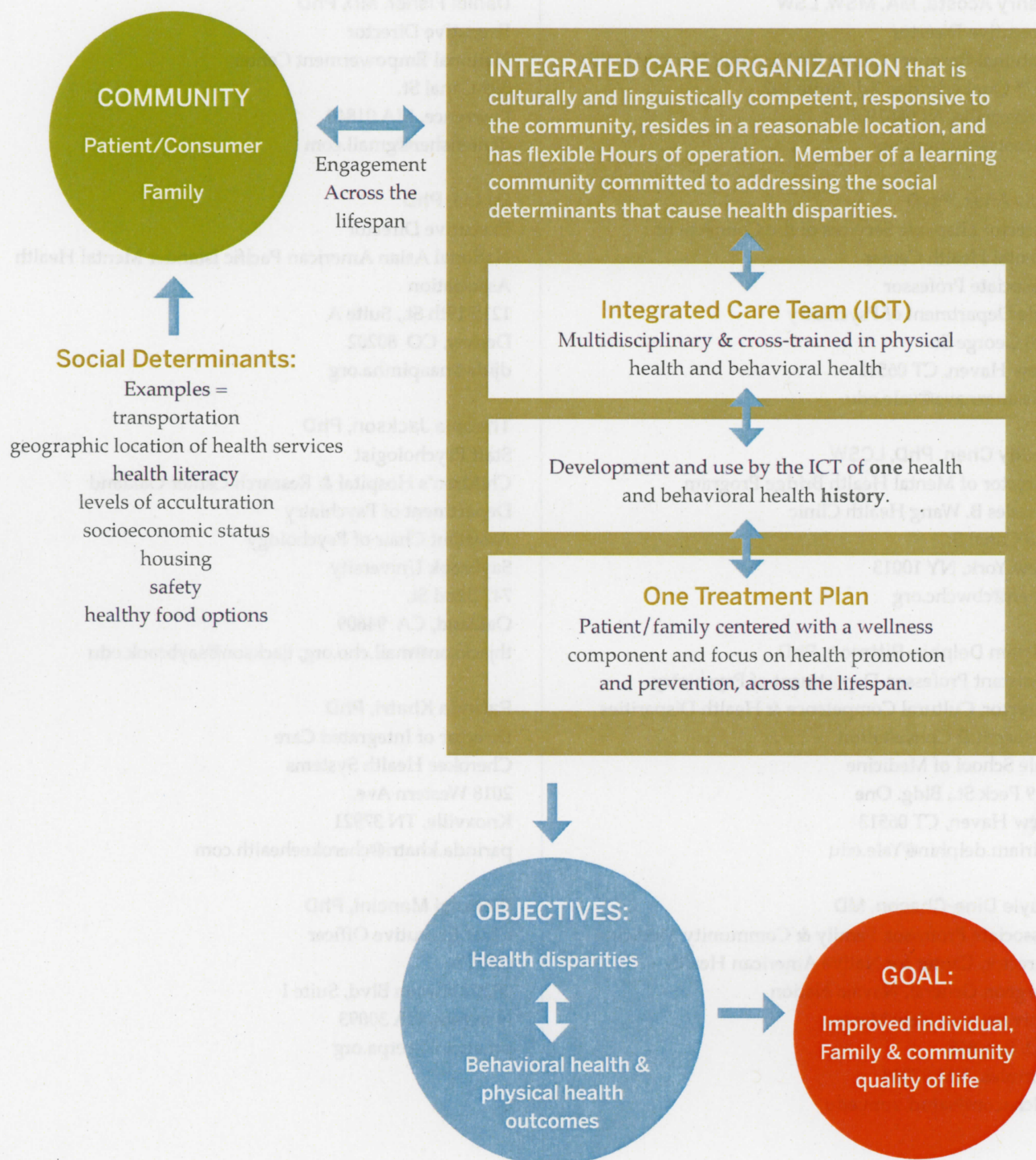
- Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., Wang, N. Y., & Ford, D. E. (2003). The acceptability of treatment for depression among African-American, Hispanic, and white primary care patients. *Medical Care*, 41(4), 479-489.
- Davis, K. (2011). *Pathways to integrated health care: Strategies for African American communities: Consensus statements and recommendations*. Rockville, MD.: U.S. Department of Health and Human Services, Office of Minority Health.
- DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2010). *Income, Poverty, and Health Insurance Coverage in the United States: 2009*. Washington, D.C.: U.S. Census Bureau.
- Doty, M. M., & Ives, B. L. (2002). *Quality of Health Care for Hispanic Populations: A Fact Sheet*: The Commonwealth Fund.
- Dwight-Johnson, M., Lagomasino, I. T., Hay, J., Zhang, L., Tang, L. Q., Green, J. M., & Duan, N. (2010). Effectiveness of Collaborative Care in Addressing Depression Treatment Preferences Among Low-Income Latinos. *Psychiatric Services*, 61(11), 1112-1118.
- Ell, K., Katon, W., Cabassa, L. J., Xie, B., Lee, P. J., Kapetanovic, S., & Guterman, J. (2009). Depression and diabetes among low-income Hispanics: Design elements of a socio-culturally adapted collaborative care model randomized controlled trial. *International Journal of Psychiatry in Medicine*, 39(2), 113-132.
- Ell, K., Katon, W., Xie, B., Lee, P. J., Kapetanovic, S., Guterman, J., & Chou, C. P. (2010). Collaborative Care Management of Major Depression Among Low-Income, Predominantly Hispanic Subjects With Diabetes A randomized controlled trial. *Diabetes Care*, 33(4), 706-713.
- Eschbach, K., Ostir, G. V., Patel, K. V., Markides, K. S., & Goodwin, J. S. (2004). Neighborhood context and mortality among older Mexican Americans: Is there a barrio advantage? *American Journal of Public Health*, 94(10), 1807-1812.
- Fernandez, A., Schillinger, D., Warton, E. M., Adler, N., Moffet, H. H., Schenker, Y., Salgado, M. V., Ahmed, A., & Karter, A. J. Language Barriers, Physician-Patient Language Concordance, and Glycemic Control Among Insured Latinos with Diabetes: The Diabetes Study of Northern California (DISTANCE). *Journal of General Internal Medicine*, 26(2), 170-176.
- Fiscella, K., Franks, P., Doescher, M. P., & Saver, B. G. (2002). Disparities in health care by race, ethnicity, and language among the insured - Findings from a national sample. *Medical Care*, 40(1), 52-59.
- Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review*, 62(3), 255-299.
- Flores, G., Fuentes-Afflick, E., Barbot, O., Carter-Pokras, O., Claudio, L., Lara, M., McLaurin, J. A., Pachter, L., Gomez, F. R., Mendoza, F., Valdez, R. B., Villarruel, A. M., Zambrana, R. E., Greenberg, R., & Weitzman, M. (2002). The health of Latino children - Urgent priorities, unanswered questions, and a research agenda. *Jama-Journal of the American Medical Association*, 288(1), 82-90.
- Fort, J. G., & McClellan, L. (2006). REACH-Meharry community-campus partnership: Developing culturally competent health care providers. *Journal of Health Care for the Poor and Underserved*, 17(2), 78-87.
- Galea, S., Tracy, M., Hoggatt, K. J., DiMaggio, C., & Karpati, A. (2011). Estimated Deaths Attributable to Social Factors in the United States. *American Journal of Public Health*, 101(8), 1456-1465.

-
- Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The behavioral model for vulnerable populations: Application to medical care use and outcomes for homeless people. *Health Services Research*, 34(6), 1273-1302.
- Gonzalez, H. M., Tarraf, W., Whitfield, K. E., & Vega, W. A. (2010). The epidemiology of major depression and ethnicity in the United States. *Journal of Psychiatric Research*, 44(15), 1043-1051.
- Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). *The Evidence Base for Cultural and Linguistic Competency in Health Care*: The Commonwealth Fund.
- Heckler, M. M. (1985). *Report of the Secretary's Task Force on Black and Minority Health*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf>.
- Heron, M., Hoyert, D. L., Murphy, S. L., Xu, J. Q., Kochanek, K. D., & Tejada-Vera, B. (2009). *Deaths: final data for 2006*. Atlanta: Centers for Disease Control and Prevention.
- Hogg Foundation for Mental Health. (2007). The Mental Health workforce in Texas: A snapshot of the issues. Retrieved March 15, 2011, from <http://www.hogg.utexas.edu/>
- Ida, D., & SooHoo, J. (2011). *Integrated care for Asian American, Native Hawaiian and Pacific Islander communities: A blueprint for action: Consensus statement and recommendations*. Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health and the National Asian American Pacific Islander Mental Health Association.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy Press.
- Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: The National Academies Press.
- Interian, A., Ang, A., Gara, M. A., Rodriguez, M. A., & Vega, W. A. (2011). The long-term trajectory of depression among Latinos in primary care and its relationship to depression care disparities. *General Hospital Psychiatry*, 33(2), 94-101.
- International City/County Management Association. (2006). *Community Health and Food Access: The Local Government Role*. Washington, D.C.
- Jackson-Triche, M. E., Greer Sullivan, J., Wells, K. B., Rogers, W., Camp, P., & Mazel, R. (2000). Depression and health-related quality of life in ethnic minorities seeking care in general medical settings. *Journal of Affective Disorders*, 58(2), 89-97.
- Kaiser Family Foundation. (2011). Health Reform Source. from www.kff.org
- Kaplan, K. (2011). Stress and aggressive breast cancer go together, study finds. *Los Angeles Times*, from <http://www.latimes.com/health/boostershots/la-heb-breast-cancer-stress-20110919,0,6194939.story>
- Katon, W., Russo, J., Lin, E. H. B., Heckbert, S. R., Ciechanowski, P., Ludman, E. J., & Von Korff, M. (2009). Depression and Diabetes: Factors Associated With Major Depression at Five-Year Follow-Up. *Psychosomatics*, 50(6), 570-579.
- Katon, W., Unutzer, J., Wells, K., & Jones, L. (2010). Collaborative depression care: history, evolution and ways to enhance dissemination and sustainability. *General Hospital Psychiatry*, 32(5), 456-464.

-
- Katon, W. J. (2008). The Comorbidity of Diabetes Mellitus and Depression. *American Journal of Medicine*, 121(11), 8-15.
- National Alliance on Mental Illness. (2007). Cultural Competence: A key for success. from http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Cultural_Competence/Cultural_Competence.htm
- National Asian American Pacific Islander Mental Health Association. (2011). Improving care for Asian American Native Hawaiian Pacific Islanders. from <http://naapimha.org/>
- Ngo-Metzger, Q., Sorkin, D. H., & Phillips, R. S. (2009). Healthcare experiences of limited English-proficient Asian American patients: A cross-sectional mail survey. *The Patient: Patient-Centered Outcomes Research*, 2(2), 113-120.
- NORC at the University of Chicago. (2010). *Trends In U.S. Public Awareness of Racial And Ethnic Health Disparities (1999-2010)* U.S. Department of Health and Human Services Office of Minority Health.
- Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report*. Washington, D.C.: U.S. Department of Health and Human Services.
- Oxman, T. E., Dietrich, A. J., & Schulberg, H. C. (2003). The depression care manager and mental health specialist as collaborators within primary care. *American Journal of Geriatric Psychiatry*, 11(5), 507-516.
- Oxman, T. E., Dietrich, A. J., & Schulberg, H. C. (2005). Evidence-based models of integrated management of depression in primary care. *Psychiatric Clinics of North America*, 28(4), 1061-+.
- Pippins, J. R., Alegria, M., & Haas, J. S. (2007). Association between language proficiency and the quality of primary care among a national sample of insured Latinos. *Medical Care*, 45(11), 1020-1025.
- President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: transforming mental health care in America. Final report*. Washington, D.C.: U.S. Department of Health and Human Services.
- Ramirez, L., Baker, E., & Metzler, M. (2008). *Promoting health equality: A resource to help communities address social determinates of health*. Atlanta: Centers for Disease Control and Prevention.
- Smedley, B. D. (2008). Moving Beyond Access: Achieving Equity In State Health Care Reform. *Health Affairs*, 27(2), 447-455.
- Taylor, P., Kochhar, R., Fry, R., Velasco, G., & Motel, S. (2011). *Wealth Gaps Rise to record highs between whites, blacks, and Hispanics*. Washington, D.C.: Pew Research Center.
- Technical Assistance Partnership for Child and Family Mental Health. (2011). *Closing the Gap: Cultural Perspectives on Family-Driven Care*. Washington, D.C.
- The Annapolis Coalition on the Behavioral Health Workforce. (2007). An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion. from http://www.annapoliscoalition.org/download_actionplan.aspx
- Thielke, S., Vannoy, S., & Unutzer, J. (2007). Integrating mental health and primary care. *Primary Care*, 34(3), 571-+.
- U.S. Department of Health and Human Services. (1999). *Mental Health: a report of the Surgeon General*. Washington, D.C.
- U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report to the Surgeon General*. Rockville, MD.

-
- University of California Irvine. (2009). The Coached Care Project: Reducing Racial Disparities in Diabetes. from <http://www.medicine.uci.edu/r2d2c2/>
- Unutzer, J., Schoenbaum, M., Druss, B. G., & Katon, W. J. (2006). Transforming Mental Health care at the interface with general medicine: Report for the President's Commission. *Psychiatric Services*, 57(1), 37-47.
- Vega, W. A., Karno, M., Alegria, M., Alvidrez, J., Bernal, G., Escamilla, M., Escobar, J., Guarnaccia, P., Jenkins, J., Kopelowicz, A., Lagomasino, I. T., Lewis-Fernandez, R., Marin, H., Lopez, S., & Loue, S. (2007). Research issues for improving treatment of US Hispanics with persistent mental disorders. *Psychiatric Services*, 58(3), 385-394.
- Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, 55(9), 771-778.
- Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in service utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry*, 156(6), 928-934.
- Velez-Ibanez, C. G. (2004). Regions of refuge in the United States: Issues, problems, and concerns for the future of Mexican-Origin populations in the United States. *Human Organization*, 63(1), 1-20.
- Warden, D., Trivedi, M. H., Wisniewski, S. R., Davis, L., Nierenberg, A. A., Gaynes, B. N., Zisook, S., Hollon, S. D., Balasubramani, G. K., Howland, R., Fava, M., Stewart, J. W., & Rush, A. J. (2007). Predictors of attrition during initial (Citalopram) treatment for depression: A STAR*D report. *American Journal of Psychiatry*, 164(8), 1189-1197.
- Weinick, R. M., Jacobs, E. A., Stone, L. C., Ortega, A. N., & Burstin, H. (2004). Hispanic healthcare disparities - Challenging the myth of a monolithic Hispanic population. *Medical Care*, 42(4), 313-320.
- Wilson, E., Chen, A. H., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of Limited English Proficiency and Physician Language on Health Care Comprehension. *JGIM: Journal of General Internal Medicine*, 20(9), 800-806.
- World Health Organization. (2009). *Improving health systems and services for mental health*. Geneva.
- World Health Organization. (2011). Face the Problem: Invest in Mental Health. from http://www.who.int/mental_health/publications/mentalhealthday_brochure_2011.pdf
- Wu, C. H., Erickson, S. R., & Kennedy, J. (2009). Patient characteristics associated with the use of antidepressants among people diagnosed with DSM-IV mood disorders: results from the National Comorbidity Survey Replication. *Current Medical Research and Opinion*, 25(2), 471-482.

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National Consensus Meeting Agenda

Meeting Objectives

1. Identify promising and practice-based approaches for delivering integrated health care to racial and ethnic minorities and populations with limited English proficiency (LEP).
2. Define and recommend key components of ideal models and approaches to delivering integrated health care to racial and ethnic minorities and populations with LEP.
3. Discuss implementation, assessment, and future research considerations related to delivering integrated health care to racial and ethnic minorities and populations with LEP.

Agenda

Day One	Monday, November 7th
8:00 am	Breakfast
9:00 am	Welcome, Remarks and Introductions <i>Octavio Martinez, Teresa Chapa</i>
9:30 am	Announcements & Meeting Packet Review <i>Meagan Longley</i>
9:40 am	Overview of Meeting Context and Rationale: Setting the Stage <i>Teresa Chapa, Rick Ybarra, Jamie Hart (facilitator)</i> <ul style="list-style-type: none">• Overview of Hogg Foundation and OMH Collaborative Effort• Meeting Objectives, Agenda and Norms
10:00 am	Examining the Field: An Overview of Integrated Care <i>Katherine Sanchez</i> <p>What does the literature tell us about the integration of healthcare (health, mental health and substance use/abuse), for racial and ethnic minorities and populations with LEP? Note: Addressing this correctly will include cultural and linguistic competence, workforce, transportation, hours of operation, and social determinants of health.</p>
10:45 am	Break

11:00 am	<p>Identification of Promising and Practice-Based Models and Approaches: Highlighting What Works</p> <ul style="list-style-type: none"> Based on your experience, what does integrated health care look like for racial and ethnic minorities and populations with LEP? What are examples of current practices or practice-based models and approaches? Are there successful models or promising practices?
12:30 pm	Lunch
1:30 pm	<p>Identification of Key Components: Developing Ideal Models of Integrated Care</p> <ul style="list-style-type: none"> Based on today's discussion of promising and practice-based models, what are the key components of effective models and approaches of integrated care? What would an ideal model or approach to integrated health care for racial and ethnic minorities and populations with LEP look like?
3:00 pm	Break
3:15 pm	Identification of Key Components: Developing Ideal Models of Integrated Care (Continued)
5:00 pm	Summary of Day One and Preparation for Day Two
5:15 pm	Adjourn
Day Two	Tuesday, November 8th
8:00 am	Breakfast
9:00 am	Reflections and Review of Findings from Day One
9:15 am	Identification of Key Components: Integrating Models and Approaches of Cultural and Linguistic Competence Into Integrated Care (Continued)
10:15 am	<p>Feedback on Implementation, Assessment, and Future Research: Applying the Recommendations</p> <ul style="list-style-type: none"> What is needed to ensure that integrated health care is provided in a culturally and linguistically appropriate way – in terms of training, policy, research / evaluation, and other strategies? How will we know that integrated health care is impacting health disparities for racial and ethnic minorities and populations with LEP? How do we build new evidence on what works?
11:30 am	<p>Next Steps: Moving Forward</p> <p><i>Rick Ybarra, Octavio Martinez, Teresa Chapa</i></p>
12:00 pm	Adjourn

Integrated Health Care Glossary

Behavioral health – A term used to refer to both mental health and substance use.

Behavioral health specialist – A mental health or substance abuse treatment provider, such as a psychiatrist, social worker, psychologist, licensed chemical dependency counselor or psychiatric nurse.

Care management – A set of evidence-based integrated care practices in which patients are educated about their behavioral health problems and regularly monitored for their response and adherence to treatment.

Clinical barriers – Obstacles to integrating care that stem from how treatment traditionally is provided and how providers traditionally are trained in different fields.

Co-location – An integrated health care approach in which both physical and mental health providers are located in the same building or on the same premises to increase access to those services and to reduce the stigma of seeking mental health treatment. Also spelled collocation.

Comorbidity – The co-existence of two or more illnesses at the same time.

Embedded primary care – An integrated health care approach in which primary care providers and behavioral health providers are located in the same practice or clinic to improve clients' physical health outcomes. Also called co-location.

Evidence-based – A treatment practice or approach that is backed by a strong body of research evidence.

Facilitated referral – An approach in which nursing staff assist clients with accessing referrals to primary care and help coordinate their care. Also called enhanced referral.

Health promotion – The provision of information and education to empower people to increase control over and improve their health.

Integrated health care – The coordination of physical and behavioral health care.

Managed care – An approach to paying for health care in which a payer controls the costs and quality of services through a variety of techniques.

Medical model – An approach to treatment in which recovery from a mental illness is defined as the reduction of symptoms and a reduced need for treatment, as contrasted with the recovery model.

Organizational barriers – Obstacles to integrating care that stem from how physical and behavioral health care organizations traditionally are structured.

Patient registry – A log or database of all patients in a clinic or practice who have a particular illness or condition.

Policy barriers – Obstacles to integrating care that stem from laws and regulations on how physical and behavioral health care organizations can provide services and share information.

Recovery model – An approach to treatment in which recovery from a mental illness is defined as the improvement of a person's quality of life and level of functioning despite the illness, as contrasted with the medical model.

Serious emotional disturbance – Mental health problems that severely limit children's ability to function at school, at home and in the family.

Severe mental illness – Term used to refer to psychiatric disorders like schizophrenia and bipolar disorder that are associated with greater disruptions in people's ability to function.

Treatment guidelines – Descriptions of best practices for assessment or management of a health condition.

Warm hand-off – An approach in which the primary care provider does a face-to-face introduction of a patient to the behavioral health specialist to which he or she is being referred.

Wellness – A state of physical, mental and spiritual well-being.

Culturally and Linguistically Competent Care: Glossary

Collecting Culturally- and Linguistically-Specific

Patient Data – Under the Affordable Care Act, to the extent practicable, federal health data collections will include culturally- and linguistically-specific data on populations served. Guidance and tools have yet to be developed. This information is included as an advisory for program planners.

Culture – Attitudes and behaviors that are characteristic of a group or community.

Cultural Competence – A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

Culturally Competent Community Engagement – The practice of working in conjunction with natural, informal support and helping networks within culturally diverse communities, encouraging communities to determine their own needs and community members to be full partners in decision making. Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners with communities benefitting economically from the collaboration.

Culturally Competent Organization – An organization that embraces the principles of equal access and non-discriminatory practices in service delivery.

Culturally Competent Practice and Service Design – The implementation of a service model that is tailored or matched to the unique needs of individuals, children, families, organizations and communities served. Practice is driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions. The service delivery model recognizes that mental health is an integral and inseparable aspect of primary health care.

Disparity – The state or condition of being unequal or different.

Family and Consumers – The recognition that family is defined differently by different cultures. Family as defined by each culture is usually the primary system of support and preferred intervention. Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.

Health Disparities – The differences in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in a population as compared to the health status of the general population.

Language Access – The provision of services, supports, and written material in the preferred language and/or mode of delivery or the use of interpretation and translation services that comply with all relevant Federal, state and local mandates governing language access.

Linguistic Competence – The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse groups including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Health Literacy – The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Plain Language – Writing that is clear and to the point, which helps to improve communication and takes less time to read and understand.